		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037895

Facility Name: Chateau Center

Address: 7050 Madison Street (Number) Willowbrook (City) 60521 (Zip Code)

County: Dupage

Telephone Number: (708) 323-6380 **Fax #** (630) 323-6416

IDPA ID Number: 22-3152473001

Date of Initial License for Current Owners: 5/1/92

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		x	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Skander Nasser, III **Telephone Number:** (317) 237-5500

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Debbie McLarty

(Title) VP of Reimbursement

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Skander Nasser, III - Partner

(Firm Name & Address) Bradley & Associates, 201 S. Capitol Ave, #910
Indianapolis, IN 46225

(Telephone) (317) 237-5500 Fax # (317) 237-5503

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Center # 0037895 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	28	Skilled (SNF)	28	10,248	1
2		Skilled Pediatric (SNF/PED)			2
3	122	Intermediate (ICF)	122	44,652	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	974	66	6,861	7,901	8
9	SNF/PED					9
10	ICF	18,832	21,609	57	40,498	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,806	21,675	6,918	48,399	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.16%

D. How many bed-hold days during this year were paid by Public Aid?
15 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 5/1/92

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/1/92 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 6,674

Medicare Intermediary Riverbend Government Benefits Administrator

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[x]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Center # 0037895 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	261,370	32,879	46,592	340,841		340,841	(4,584)	336,257			1
2	Food Purchase		208,790		208,790		208,790	(16,620)	192,170			2
3	Housekeeping	134,413	25,354		159,767		159,767		159,767			3
4	Laundry	10,192	31,606		41,798		41,798		41,798			4
5	Heat and Other Utilities			151,268	151,268		151,268		151,268			5
6	Maintenance	70,345	24,206	105,273	199,824		199,824		199,824			6
7	Other (specify):*											7
8	**TOTAL General Services**	476,320	322,835	303,133	1,102,288		1,102,288	(21,204)	1,081,084			8
	B. Health Care and Programs											
9	Medical Director			36,500	36,500		36,500		36,500			9
10	Nursing and Medical Records	2,331,303	112,974	47,329	2,491,606		2,491,606	(5,708)	2,485,898			10
10a	Therapy	4,646	4,700	573,489	582,835		582,835	(16,098)	566,737			10a
11	Activities	93,074	10,146	1,841	105,061		105,061		105,061			11
12	Social Services	69,268	323	770	70,361		70,361		70,361			12
13	Nurse Aide Training											13
14	Program Transportation					8,979	8,979		8,979			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,498,291	128,143	659,929	3,286,363	8,979	3,295,342	(21,806)	3,273,536			16
	C. General Administration											
17	Administrative	111,588			111,588	(59,729)	51,859	604,583	656,442			17
18	Directors Fees											18
19	Professional Services			91,036	91,036	(1,090)	89,946	(87,717)	2,229			19
20	Dues, Fees, Subscriptions & Promotions			560	560	1,090	1,650	(540)	1,110			20
21	Clerical & General Office Expenses	92,472	33,968	72,597	199,037	59,729	258,766		258,766			21
22	Employee Benefits & Payroll Taxes			678,784	678,784		678,784		678,784			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,658	10,658	(8,979)	1,679		1,679			24
25	Other Admin. Staff Transportation			2,061	2,061		2,061		2,061			25
26	Insurance-Prop.Liab.Malpractice			34,425	34,425		34,425		34,425			26
27	Other (specify):* Misc exp			115,231	115,231		115,231	(110,373)	4,858			27
28	**TOTAL General Administration**	204,060	33,968	1,005,352	1,243,380	(8,979)	1,234,401	405,953	1,640,354			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,178,671	484,946	1,968,414	5,632,031		5,632,031	362,943	5,994,974			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Chateau Center #0037895 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			110,665	110,665		110,665	56,185	166,850			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							235,353	235,353			32
33	Real Estate Taxes			80,713	80,713		80,713		80,713			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			41,929	41,929		41,929		41,929			35
36	Other (specify):*											36
37	**TOTAL Ownership**			233,307	233,307		233,307	291,538	524,845			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			360,581	360,581		360,581	(12,040)	348,541			39
40	Barber and Beauty Shops			14,037	14,037		14,037		14,037			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			103,050	103,050		103,050		103,050			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			477,668	477,668		477,668	(12,040)	465,628			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,178,671	484,946	2,679,389	6,343,006		6,343,006	642,441	6,985,447			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Center # 0037895 Report Period Beginning: 1/1/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(15,685)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	10,352	30		9
10	Interest and Other Investment Income	(72)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(935)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(103,888)	27		24
25	Fund Raising, Advertising and Promotional	(6,485)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See page 5a	(88,257)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (204,970)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	847,411		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 847,411		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 642,441		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Chateau Center

ID# 0037895

Report Period Beginning: 1/1/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	NON ALLOWABLE LEGAL FEES	$ (87,717)	19	1
2	PAC DUES	(540)	20	2
3				3
4				4
5				5
6				6
7				7
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85				85
86				86
87				87
88				88
89				89
90	**Total**	(88,257)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Chateau Center # 0037895 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	(4,584)	0	0	0	0	0	0	0	0	0	(4,584)	1
2	Food Purchase	(16,620)	0	0	0	0	0	0	0	0	0	0	(16,620)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(16,620)	(4,584)	0	0	0	0	0	0	0	0	0	(21,204)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(5,708)	0	0	0	0	0	0	0	0	0	(5,708)	10
10a	Therapy	0	(16,098)	0	0	0	0	0	0	0	0	0	(16,098)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(21,806)	0	0	0	0	0	0	0	0	0	(21,806)	16
	C. General Administration													
17	Administrative	0	604,583	0	0	0	0	0	0	0	0	0	604,583	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(87,717)	0	0	0	0	0	0	0	0	0	0	(87,717)	19
20	Fees, Subscriptions & Promotions	(540)	0	0	0	0	0	0	0	0	0	0	(540)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(110,373)	0	0	0	0	0	0	0	0	0	0	(110,373)	27
28	**TOTAL General Administration**	(198,630)	604,583	0	0	0	0	0	0	0	0	0	405,953	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(215,250)	578,193	0	0	0	0	0	0	0	0	0	362,943	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Chateau Center # 0037895 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	10,352	45,833	0	0	0	0	0	0	0	0	0	56,185	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(72)	235,425	0	0	0	0	0	0	0	0	0	235,353	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	10,280	281,258	0	0	0	0	0	0	0	0	0	291,538	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(12,040)	0	0	0	0	0	0	0	0	0	(12,040)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	(12,040)	0	0	0	0	0	0	0	0	0	(12,040)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(204,970)	847,411	0	0	0	0	0	0	0	0	0	642,441	45

Facility Name & ID Number Chateau Center # 0037895 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Genesis Health Ventures	100	See attached list		CVN, Inc.	Hackensack, NJ	Property Owner
				Neighborcare	Willowbrook, NJ	Pharmacy
				Genesis Rehab	Kennett Square,PA	Therapy
				Genesis Hospitality	Kennett Square,PA	Dietary

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	Depreciation	$	CVN, Inc.		$ 45,833	$ 45,833	1
2	V	32	Interest		CVN, Inc.		235,425	235,425	2
3	V	17	Administrative		Genesis Health Ventures, Inc.	100.00%	604,583	604,583	3
4	V	1	Related party mark-up	117	Neighborcare			(117)	4
5	V	10	Related party mark-up	5,708	Neighborcare			(5,708)	5
6	V	10a	Related party mark-up	53	Neighborcare			(53)	6
7	V	39	Related party mark-up	12,040	Neighborcare			(12,040)	7
8	V	10a	Related party mark-up	16,045	Genesis Rehab			(16,045)	8
9	V	1	Related party mark-up	4,467	Genesis Hospitality			(4,467)	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 38,430			$ 885,841	$ * 847,411	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Center # 0037895 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Facility is owned by a publicly traded company								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Chateau Center # 0037895 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Genesis Health Ventures
Street Address: 101 E. State Street
City / State / Zip Code: Kennett Square, PA
Phone Number: (610) 925-4076
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Accumulated Cost		58	$ 19,764,727	$		$ 604,583	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 19,764,727	$		$ 604,583	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Center # 0037895 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Mellon Bank Revolving		x				$ 2,339,044	$ 1,276,502		8.5000	$ 164,021	1
2	Mellon Bank Revolving		x				709,425	709,425		8.5000	71,404	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 3,048,469	$ 1,985,927			$ 235,425	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,048,469	$ 1,985,927			$ 235,425	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Chateau Center # 0037895 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	111,151	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	70,516	2
3. Under or (over) accrual (line 2 minus line 1).	$	(40,635)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	121,348	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	80,713	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	83,852	8
	1996	68,736	9
	1997	70,540	10
	1998	142,129	11
	1999	70,516	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Chateau Center # 0037895 Report Period Beginning: 1/1/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,447 B. General Construction Type: Exterior Brick Frame Masonry & Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	273,121	1992	$ 30,000	1
2					2
3	TOTALS	273,121		$ 30,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Center # 0037895 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		1992	1987	$ 1,500,000	$	30	$ 45,833	$ 45,833	$ 429,166	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1992	22,258	505	20	1,113	608	8,895	9
10	LEASEHOLD IMPROVEMENTS			1993	3,561	86	20	178	92	1,289	10
11	LEASEHOLD IMPROVEMENTS			1994	125,617	3,227	20	6,282	3,055	37,690	11
12	LEASEHOLD IMPROVEMENTS			1995	26,955	737	20	1,931	1,194	8,555	12
13	CAPITALIZED INTEREST			1996	10,079	286	20	453	167	2,015	13
14	BUILDING PERMIT			1996	394	11	20	20	9	84	14
15	PAINTING			1996	52,194	1,481	20	2,348	867	10,437	15
16	CORNER GUARDS & WALLCOVERINGS			1996	4,824	137	20	241	104	1,012	16
17	DOORS			1996	228	6	20	11	5	47	17
18	WALLPAPER HANGING			1996	48,510	1,376	20	2,182	806	9,700	18
19	PLUMBING			1996	53,200	1,509	20	2,394	885	10,640	19
20	BLUEPRINTS			1996	81	2	20	4	2	17	20
21	CARPET			1996	32,947	935	20	1,482	547	6,588	21
22	INSTALL CARPET			1996	11,624	330	20	523	193	2,324	22
23	ARCHITECT FEES			1996	11,502	326	20	517	191	2,299	23
24	DRAPES			1996	4,471	127	20	224	97	940	24
25	INSTALL FLOORING			1996	12,830	364	20	577	213	2,566	25
26	NURSECALL FIRE ALARM			1996	16,745	475	20	753	278	3,348	26
27	WALL COVERING			1996	611	17	20	31	14	130	27
28	INTERIOR SIGN			1996	2,700	77	20	135	58	567	28
29	PAINT & WALLPAPER			1996	1,922	55	20	96	41	403	29
30	INSTALL CARPET			1996	293	8	20	15	7	63	30
31	CARPET			1996	22,456	637	20	879	242	4,228	31
32	PLUMBING			1996	7,010	199	20	351	152	1,474	32
33	WALLCOVERING			1996	3,748	106	20	187	81	786	33
34	INSTALL FLOORING			1996	16,158	458	20	727	269	3,231	34
35	DOORS			1996	413	12	20	21	9	88	35
36	TOTAL (lines 4 thru 35)				$ 1,993,331	$ 13,489		$ 69,508	$ 56,019	$ 548,582	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Center # 0037895 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SIGNS			1996	3,715	105	20	186	81	618	9
10	ENGINEERING FEE			1996	900	26	20	45	19	189	10
11	ACROVYN & CORNER GUARDS			1996	6,784	192	20	339	147	1,424	11
12	ARCHITECT FEES			1996	4,295	122	20	214	92	901	12
13	PAINTING & WALLCOVERINGS			1996	22,843	648	20	896	248	4,304	13
14	CAPITALIZED INTEREST			1996	16,448	467	20	740	273	3,289	14
15	ROOFING			1997	2,900	83	20	145	62	589	15
16	ILLINOIS DRILLING			1997	900	26	20	45	19	180	16
17	FLOOR COVERINGS			1997	2,755	79	20	138	59	551	17
18	COMPUTER CABLE			1997	320	9	20	16	7	61	18
19	WALLPAPER			1997	2,640	76	20	135	59	533	19
20	FLOORCXOVERING			1997	45	2	20	2		8	20
21	PROPERTY INSPECTIONS			1997	500	14	20	25	11	99	21
22	CARPETING			1997	308	9	20	15	6	56	22
23	CARPETING			1997	289	8	20	14	6	52	23
24	SECURITY & COMMUNICATIONS SYSTEM			1997	1,195	35	40	27	(8)	107	24
25	SECURITY & COMMUNICATIONS SYSTEM			1997	718	21	40	16	(5)	63	25
26	HVAC REPAIR			1997	2,071	61	40	48	(13)	190	26
27	WALL & TILE BASE			1997	2,199	65	40	49	(16)	196	27
28	BRICK			1997	6,820	201	40	153	(48)	613	28
29	CARPETING			1997	4,476	132	40	101	(31)	394	29
30	LAUNDRY MACHINES			1997	4,399	130	40	99	(31)	379	30
31	CAPITALIZED INTEREST			1997	454	13	20	20	7	76	31
32	SHOWER ROOM VALVE REPAIR			1997	370	11	20	19	8	72	32
33	SHOWER ROOM VALVE REPAIR			1997	295	9	20	15	6	58	33
34	TECHNICIAN FEES			1997	4,500	132	20	160	28	728	34
35	PLUMBING SUPPLIES			1997	120	5	20	6	1	24	35
36	TOTAL (lines 4 thru 35)				$ 93,259	$ 2,681		$ 3,668	$ 987	$ 15,754	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Center # 0037895 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SHOWER RODS			1997	132	5	20	7	2	27	9
10	SHOWER REPAIR			1997	56	2	20	3	1	14	10
11	PAINTING			1997	10,900	320	20	350	30	1,614	11
12	CONCRETE PATCH WORK			1997	4,300	126	20	100	(26)	560	12
13	PAINTING			1997	2,690	79	20	90	11	395	13
14	ELECTRICAL WORK			1997	750	22	20	30	8	114	14
15	FAUCETS			1997	364	11	20	18	7	62	15
16	SEWAGE PUMP WATER ALARM			1997	907	27	20	35	8	141	16
17	PLUMBING COPPER			1997	1,038	31	20	41	10	162	17
18	LUMBING VALVE GUAGE			1997	243	7	20	12	5	43	18
19	PAINTING			1997	1,800	54	20	71	17	260	19
20	PAINTING			1997	1,490	45	20	66	21	231	20
21	GENERATOR REPAIR			1997	770	23	20	30	7	111	21
22	GENERATOR REPAIR			1997	1,564	47	20	78	31	258	22
23	ELECTRICAL WORK			1997	1,283	50	35	37	(13)	119	23
24	CONCRETE PATCH WORK			1997	5,700	175	35	125	(50)	450	24
25	INSTALLATION & REMOVAL OF DOOR			1997	1,160	46	35	33	(13)	107	25
26	PAINTING			1997	1,790	71	35	60	(11)	184	26
27	AMERICAN INDUSTRIAL CLEANING			1997	11,600	300	35	250	(50)	906	27
28	UNDERGROUND TANK REMOVAL			1998	7,970	154	35	154		462	28
29	UNDERGROUND TANK REMOVAL			1998	1,700	33	35	33		99	29
30	UNDERGROUND TANK REMOVAL			1998	1,700	29	35	29		87	30
31	UNDERGROUND TANK REMOVAL			1998	7,970	136	35	136		408	31
32	TILE IN KITCHEN			1998	1,047	16	35	16		48	32
33	UNDERGROUND TANK REMOVAL			1998	6,936	104	35	104		312	33
34	HEAT & AIR ROOF UNIT			1998	808	10	35	10		30	34
35	CARPET FOR LOBBY			1998	2,141	23	35	23		69	35
36	TOTAL (lines 4 thru 35)				$ 78,809	$ 1,946		$ 1,941	$ (5)	$ 7,273	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Center # 0037895 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	HEAT & AIR ROOF UNITS			1998	808	8	35	8		24	9
10	HEAT & AIR ROOF UNITS			1998	690	8	35	8		24	10
11	HEAT & AIR ROOF UNITS			1998	243	3	35	3		9	11
12	UNDERGROUND TANK REMOVAL			1998	7,970	85	35	85		255	12
13	REPAIR HEAT MOTOR EXHAUST DUCT			1998	411	1	35	1		3	13
14	REPAIR HEAT MOTOR EXHAUST DUCT			1998	11,670	25	35	25		75	14
15	REPAIR HEAT MOTOR EXHAUST DUCT			1998	1,160	2	35	2		6	15
16	REPAIR HEAT MOTOR EXHAUST DUCT			1998	860	2	35	2		6	16
17	REPAIR HEAT MOTOR EXHAUST DUCT			1998	290	1	35	1		3	17
18	REPAIR HEAT MOTOR EXHAUST DUCT			1998	694	1	35	1		3	18
19	CAPITALIZED INTEREST			1997	175	4	30	6	2	24	19
20	CAPITALIZED INTEREST			1997	850	22	30	28	6	103	20
21	CAPITALIZED INTEREST			1997	437	11	30	15	4	58	21
22	INSTALL WINDOWS			1997	694	18	30	23	5	86	22
23	TILE IN DISH AREA			1999	1,363	39	35	39		78	23
24	GREASE TRAP REPLACEMENT			1999	8,172	233	35	233		466	24
25	ADJUST LOCKS ON DOORS			1999	425	12	35	12		24	25
26	WANDERGUARD			1999	164	5	35	5		10	26
27	EXTERIOR SIGN			1999	3,000	86	35	86		172	27
28	RADIO TRANSMITTER FOR FIRE ALARM			1999	1,527	44	35	44		88	28
29	SEVERAL FIRE DOORS			1999	4,460	127	35	127		251	29
30	TILE KITCHEN			1999	3,200	91	35	9	(82)	18	30
31	GENERATOR			1999	7,896	226	35	226		452	31
32	SHADES			1999	351	10	35	10		20	32
33	INSTALL CYL ON ELEVATOR			1999	361	10	35	10		20	33
34	REPAIRED GAS LEAKS ON BOILER			1999	1,518	43	35	43		86	34
35	PAINT & SUPPLIES			1999	646	18	35	18		36	35
36	TOTAL (lines 4 thru 35)				$ 60,035	$ 1,135		$ 1,070	$ (65)	$ 2,400	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Center # 0037895 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SMOKE WALL			1999	4,356	124	35	124		248	9
10	PAINT & SUPPLIES			1999	311	9	35	9		18	10
11	REPAIR HOLE IN FLOOR			1999	479	14	35	14		28	11
12	DOUBLE DOORS			2000	3,283	94	35	94		94	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 8,429	$ 241		$ 241	$	$ 388	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Center # 0037895 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 527,826	$ 69,571	$ 86,026	$ 16,455	5-7	$ 511,645	37
38	Current Year Purchases	30,773	4,396	4,396		7	4,396	38
39	Fully Depreciated Assets	432,041					432,041	39
40								40
41	TOTALS	$ 990,640	$ 73,967	$ 90,422	$ 16,455		$ 948,082	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 3,254,503	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 93,459	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 166,850	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 73,391	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,522,479	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Chateau Center # 0037895 Report Period Beginning: 1/1/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 29,701 Description: Nrsg $3300, Maint $6328, Diet $170, Laund $8604, Admin $11299
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility Use	1999 Plymouth Voyager	$ 409.00	$ 4,908	17
18	Laundry Van	1999 Cargo Van	610.00	7,320	18
19					19
20					20
21	TOTAL		$ #######	$ 12,228	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Center # 0037895 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Center

STATE OF ILLINOIS
0037895 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A, 3	hrs	$	4,444	$ 244,421	$	4,444	$ 244,421	1
2	Licensed Speech and Language Development Therapist	10A, 3	hrs		1,162	63,887		1,162	63,887	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A, 1-3	584 hrs	4,646	4,734	260,364	4,700	5,318	269,710	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 3	# of prescrpts				253,243		253,243	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): RT	10a, 3			88	4,817		88	4,817	13
14	TOTAL			$ 4,646	10,428	$ 573,489	$ 257,943	11,012	$ 836,078	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Chateau Center # 0037895 Report Period Beginning: 1/1/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 69,078	$ 69,078	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,579,164	1,579,164	3
4	Supply Inventory (priced at)	18,813	18,813	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,667,055	$ 1,667,055	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		30,000	13
14	Buildings, at Historical Cost		1,500,000	14
15	Leasehold Improvements, at Historical Cost	1,382,470	1,382,470	15
16	Equipment, at Historical Cost	992,519	992,519	16
17	Accumulated Depreciation (book methods)	(922,691)	(1,351,858)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Other assets	(400)	(400)	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,451,898	$ 2,552,731	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,118,953	$ 4,219,786	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 534,752	$ 534,752	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	114,054	114,054	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	121,348	121,348	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other liab	225,909	225,909	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 996,063	$ 996,063	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to related party	(7,495,861)	(6,219,363)	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (7,495,861)	$ (6,219,363)	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (6,499,798)	$ (5,223,300)	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 9,618,751	$ 9,443,086	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,118,953	$ 4,219,786	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Facility Name & ID Number Chateau Center # 0037895 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 7,800,400	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 7,800,400	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,818,351	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,818,351	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 9,618,751	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Center # 0037895 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,207,581	1
2	Discounts and Allowances for all Levels	237,680	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,445,261	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	323,272	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 323,272	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	18,202	13
14	Non-Patient Meals	15,686	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	67,551	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,028	19
20	Radiology and X-Ray	47,040	20
21	Other Medical Services	236,245	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 392,752	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	72	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 72	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,161,357	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,102,288	31
32	Health Care	3,286,363	32
33	General Administration	1,243,380	33
	B. Capital Expense		
34	Ownership	233,307	34
	C. Ancillary Expense		
35	Special Cost Centers	374,618	35
36	Provider Participation Fee	103,050	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,343,006	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,818,351	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,818,351	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Chateau Center # 0037895 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,778	4,210	$ 132,643	$ 31.51	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	137,288	153,001	2,198,659	14.37	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist	524	584	4,646	7.96	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,553	8,413	93,074	11.06	10
11	Social Service Workers	3,604	3,859	69,268	17.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,218	26,924	261,370	9.71	15
16	Dishwashers					16
17	Maintenance Workers	5,394	6,014	70,346	11.70	17
18	Housekeepers	16,927	18,810	134,413	7.15	18
19	Laundry	1,155	1,302	10,192	7.83	19
20	Administrator	1,213	1,379	51,859	37.61	20
21	Assistant Administrator					21
22	Other Administrative	10,167	11,561	152,201	13.17	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	211,821	236,057	$ 3,178,671 *	$ 13.47	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	monthly	36,500	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	per bed charge	21,214	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 57,714		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Chateau Center # 0037895 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Earl Van Duesen	Administrator	0	$ 51,859
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 51,859

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Daune Morris & Heckscher	Legal	$ 118
Various	Acctg	2,111
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 2,229

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 132,054
Unemployment Compensation Insurance	75,176
FICA Taxes	244,061
Employee Health Insurance	177,581
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Misc Other	17,125
Retirement	15,009
Recruitment	17,778
TOTAL (agree to Schedule V, line 22, col.8)	$ 678,784

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
IL Health Care Assoc dues	4,365
Adj of prior year expense	(3,255)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,110

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	688
Seminar Expense	991
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,679

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Chateau Center # 0037895 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Chateau Center # 0037895 Report Period Beginning: 1/1/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL Health Care Assoc $4365

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 7

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 93,077 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 103,050
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? YES Indicate the amount. $ 15,685

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: KPMG Peat Marwick The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. NOT YET AVAILABLE

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.